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MEDICAL CARE FOR RECIPIENTS OF  
THE SOCIAL SECURITY AIDS  
IN WISCONSIN  
1939

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Wisconsin. State Pension Dept.

MEDICAL CARE FOR RECIPIENTS OF  
THE SOCIAL SECURITY AIDS  
IN WISCONSIN  
1939

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State Pension Department  
315 S. Carroll Street  
Madison, Wisconsin

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STATE PENSION DEPARTMENT OF WISCONSIN

Madison, Wisconsin

To County Administrations of Social Security Aids:

The attached bulletin entitled "Medical Care for Recipients of the Social Security Aids in Wisconsin--1939" incorporates the results of a study conducted by this department during the past few months at the request of the county pension administrations of this state. It is hoped that the report affords information that will be informative and valuable to you in your work of administering the social security aids in your county.

The splendid cooperation and assistance of all county pension administrators, of members of the county medical societies, of Mr. George Crownhart, Secretary of the State Medical Society, and of the staff of the State Pension Department, are gratefully acknowledged. The study itself has been carried on under the direction of and this report has been prepared by Messrs. Lyman Haunschild and Marshall W. Keith, District Supervisors in this department.

In addition to the assistance which this bulletin is hoped to give, the State Pension Department offers the services of the district supervisors throughout the state. The State Medical Society, Washington Building, Madison, Wisconsin, will also be glad, upon request, to assist in planning and developing a medical program and has valuable information relating to agreements, fee schedules and other pertinent information which may be utilized.

Very truly yours,

George M. Keith  
Supervisor of Pensions

Gift to Oc 59



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## CHAPTER I

### LEGAL PHASES

Laws and policies governing the procedures of the Social Security Board and State Pension Department

The Social Security Act of the United States which became law August 14, 1935, does not include a definite provision to the effect that medical assistance shall be rendered to needy aged, to dependent children and to blind beneficiaries. However, the Social Security Board has interpreted the word "needy" to permit provision not only for the necessities of life, such as food, clothing and shelter, but also for medical care and attention. This interpretation permits participation by the federal government only when the amount allowed for medical care and attention is included in the grant to the beneficiary. Such restriction arises from limitations written into the Social Security Act and reviewed hereafter.

After establishing the procedure by which the several states may be aided by the federal government in providing for the general welfare of aged individuals, of blind persons and of dependent children who are in need and can comply with the requirements of the Social Security Act and the respective state laws, Section 6 of Title I of the Social Security Act provides: "When used in this Title the term 'old age assistance' means money payments to needy aged individuals." Section 406 (b), Title IV of the Social Security Act provides: "The term 'aid to dependent children' means money payments with respect to a dependent child or dependent children." Section 1006 of Title X provides: "When used in this Title the term 'aid to the blind' means money payments to blind individuals who are needy." In view of these provisions of the Social Security Act the Social Security Board refuses to participate in payments which are not money payments or payments the use or disposal of which by the

eligible payee is restricted. Thus, the Social Security Board refuses to make money reimbursement to the State of Wisconsin where payment for medical care of a beneficiary of old age assistance, blind pension or aid to dependent children is made directly to the physician or hospital rendering such care by the county pension authority.

This position of the Social Security Board is set forth in a letter addressed to the State Pension Department dated September 6, 1938, from Martha E. Phillips, Regional Representative of the Bureau of Public Assistance of the Social Security Board, which letter reads as follows:

"Under the Board's interpretation of Title I, Section 6, of the Social Security Act, only those money payments are matchable with Federal funds that are unconditionally paid to the aged applicant or his duly authorized legal guardian. Any payment to an individual, other than the aged applicant or his legal guardian, whether on behalf of the aged applicant or for his use or otherwise, cannot be matched with federal funds. Further, even though a payment is made by a check payable to the order of the aged applicant, if such check is delivered to an individual other than the aged applicant or his legal guardian, or is delivered to the aged applicant subject to any agreement express or implied that the ownership or control of the expenditure of the proceeds of such check is subject directly or indirectly to the dominion of a person who is not the aged applicant or his legally appointed guardian, such payment cannot be matched with federal funds. In brief, the criterion of matchability is whether or not the payment consists of an unconditional transfer and delivery of money to the applicant for expenditure by him in his uncontrolled discretion."

It would appear that the statements in this letter not only apply to old age assistance payments but also to blind pension and aid to dependent children payments since the Social Security Act requires that these two aids, the same as old age assistance, shall be money payments to persons eligible to receive aid. The State Pension Department's policy must accord with the rules and policies of the Social Security Board. The policy of avoiding restrictive payments can be observed in all cases and still prevent misuse of public

funds. In some instances where additional protection to assure proper use of aid given is necessary, a more intensive supervision of such cases by the County Department might be indicated on a selective basis. It is neither necessary nor advisable to give close supervision to all beneficiaries for whom an increase in aid is granted to permit paying for medical care and attention.

Aid to Dependent  
Children

In the aid to dependent children law of the State of Wisconsin there is found the following statement regarding the inclusion of medical care and attention in the aid to dependent children grant for beneficiaries: Section 48.33 (6), "Medical and dental aid may be granted to minor children, the mother or the incapacitated father, as necessary . . . . Aid pursuant to this section shall be the only form of public assistance granted to the family for the benefit of such child except medical and dental aid . . . . "

The pertinent opinions of the Attorney General interpreting the above quoted provisions of the aid to dependent children law are now considered. In 20 OAG 146 it was held that medical aid given to an indigent family of the City of Crandon at the request of the poor commissioner of the city must be paid for by the city although the mother receives aid under Section 48.33. The opinion states: "Under Section 49.01 it is the duty of the city to relieve the indigent, and this includes medicine. Under these various provisions medical aid may be granted under the mothers' pension law, as well as by the city under Section 49.01. In this case the medical aid was performed by Dr. G. W. Ison at the request of the poor commission of the city and it was not furnished under the mothers' pension law by the county authorities. I am therefore of the

opinion that the city is liable for this medical aid instead of the county." The inference from this opinion is that medical aid may or may not be granted under the aid to dependent children statutes. In 19 OAG 468 it was held that a family which receives aid to dependent children may not be granted any other form of public assistance except medical and dental aid and that medical and dental aid authorized by the county judge is a charge upon the county, and further, that the town may also furnish medical and dental aid at its expense. The opinion states: "The judge may also authorize medical and dental aid for minor children . . . and if so authorized, the cost thereof becomes a charge upon the county in the same manner as other aids supplied under the provisions of Section 48.33. Inasmuch as medical and dental aid are excepted from the provisions of Section 48.33 (6), the town authorities may furnish at the expense of the town such relief to the family in the event that the judge has not authorized such medical or dental aid, or to those members of the family whose medical or dental aid is not provided for by the authorization of the court. If such medical or dental aid is authorized and furnished by the town authorities, the cost thereof is a charge upon the town." The general tenor of the above opinions is that the county pension authorities may or may not within their discretion allow for medical care in computing the aid to dependent children grant.

The most recent opinion on this question which appears to affirm previous opinions was given to the State Pension Department on July 11, 1939. In this opinion the Attorney General holds that the aid to dependent children grant may include an amount to care for the medical needs of the incapacitated father if he is in the home, even though such father may not be the supervising adult. This opinion has direct bearing on the meaning of the language "may be granted . .

as necessary" set forth in the above quoted part of Section 48.33 (6) of the Wisconsin Statutes. The Attorney General in his recent opinion referring to the medical needs of the incapacitated father said: "Such grant would be within the sound discretion of the granting agency as is indicated by the wording 'may be granted . . . as necessary'. This does not mean, however, that aid could be arbitrarily refused in a proper and meritorious case. The status is mandatory to the extent that the discretion vested may not be exercised viciously and inefficiently. The rule of reason must govern in such matters and in the absence of abuse, it is unlikely that the results reached in a particular case would be disturbed by the courts on review." This statement, it is submitted, means that the county pension administration has certain authority based on the exercise of sound discretion to determine whether medical aid should be included in the aid to dependent children grant for either the minor child, the supervising adult, or incapacitated father.

On the question of whether the word medical as used in Section 48.33 (6) of the Wisconsin Statutes includes hospitalization, the State Pension Board on February 20, 1937, adopted the following regulation: ". . . the word 'medical' might properly be interpreted to include emergency hospitalization for the child or mother subject to the requirement of such expense being incurred only with the permission and approval of the county pension authorities." In view of the recent unofficial opinion of the Attorney General above outlined concluding that the medical needs of the incapacitated father might be provided for even though he is not the supervising adult, it would appear that hospitalization for the incapacitated father would be included within this holding. Thus, in summarizing this section it is believed that the provisions of Section 48.33 (6) of the Wisconsin Statutes indicate that the Legislature of the State

of Wisconsin intended that the medical care of minor dependent children and the supervising adult together with the medical care of the incapacitated father, even though he is not the supervising adult, should be included in the aid to dependent children grant whenever possible.

Blind Pension

The blind pension law does not directly mention medical needs. Section 47.08 (1) of the Wisconsin Statutes on blind pensions, however, provides in part: "Any needy person eighteen years of age or more, who is blind or blind and deaf, shall be entitled to receive from the county of which he or she is a resident an annual pension payable monthly." By use of the term "needy" the State Pension Department believes that the Legislature intended to include the medical needs of recipients as well as their needs for food, clothing, shelter and other necessities. This view is supported by an analogy arising from an interpretation by the Attorney General of Section 49.31 (1) of the old age assistance law. This section of the old age assistance law provides that the only form of aid a beneficiary may receive other than old age assistance is medical and surgical aid, implying that these needs might not be provided through the old age assistance grant. However, as previously stated in 26 OAG 306, the Attorney General held that such needs should be included in the old age assistance grant if the grant does not exceed the maximum of one dollar per day.

In view of this opinion and the provisions of Section 49.31 (1), it is concluded that the Legislature must have intended that the blind pension grant should include the pensioner's medical needs up to the maximum amount allowed by law since there is no provision in the blind pension law for payment for medical services, even to the effect that such care be provided by the relief authorities. After the maximum is reached medical care should be furnished by the relief authorities under the general provisions of the relief laws.

Old Age Assistance      Section 49.20 of the Wisconsin Statutes provides that a state system of old age assistance is established "for the more humane care of aged dependent persons." Section 49.21 of the Wisconsin Statutes provides in part: "The amount . . . old age assistance shall be fixed with due regard to the conditions in each case . . . " Section 49.31 (1) of the Wisconsin Statutes provides: "During the continuance of old age assistance no beneficiary shall receive any other relief from the state or from any political subdivision thereof except for medical and surgical assistance."

An opinion of the Attorney General of Wisconsin reported in 26 OAG 306 indicates that medical care and attention are an integral and important part of the old age assistance program. The two significant statements in this opinion are as follows: 1. "We see no reason why it would not be possible to temporarily increase old age assistance from \$20 to \$30 per month for five months where a beneficiary receiving old age assistance from X county in the amount of \$20 subsequently becomes ill and requires hospitalization costing \$50 with the understanding that the \$10 per month increase is to be applied to the hospital bill." 2. "If the physical condition of the applicant is such as to call for medical care, such condition should be given due regard under Section 49.21, subsection (2), Statutes, in fixing the amount of the old age assistance grant within the maximum limits of one dollar a day."

This Attorney General's opinion indicates that it is proper practice under Wisconsin Law for county pension administrations to include provision for paying the cost of not only chronic medical needs but also of emergency medical care including hospitalization expense in an old age assistance recipient's grant. Thus, if Mr. A of X county, who is in receipt of old age assistance in the amount of \$20 per month, undergoes an operation for appendicitis and his total expense for the appendectomy, physician's services, medicine, surgical supplies, nurse,

if necessary, and hospitalization amounts to \$100, A's grant of old age assistance may be temporarily increased from \$20 to \$30 per month with the expectation that \$10 each month is to be applied by the beneficiary to the \$100 item of indebtedness for such medical and surgical attention.

To carry this example one step further, assume that Mr. A is receiving \$30 per month old age assistance for his ordinary living expenses while being cared for in a hospital. In such an event the Attorney General further holds (26 OAG 306) that the necessary medical care and attention may be supplied through the regular relief channels. The Attorney General said on this point: " . . . where the conditions of the pensioner is such that the maximum allowance of one dollar a day under Section 49.29 (should be 49.21) is insufficient to provide necessary medical and surgical care . . . if the person is without other resources, it would, of course, be proper to supplement the maximum old age assistance allowance with medical and surgical care through regular relief channels". This statement affirms a previous opinion of the Attorney General cited as 25 OAG 287. In 19 OAG 548, which is definitely clarified by 26 OAG 306, the Attorney General held that where one is receiving old age assistance in the amount of \$15 per month, the court cannot allow a hospital bill out of old age assistance funds in addition to be paid on account of expense incurred for keeping the beneficiary in the hospital. This opinion does not mean that the old age assistance grant could not have been increased to the maximum amount to permit paying the hospital bill, as 26 OAG 306 clearly holds. While Section 49.31 of the old age assistance statutes, above quoted, seems to indicate that the medical needs of an old age assistance beneficiary should be paid by the relief authorities even though the beneficiary is not receiving the maximum grant of old age assistance, the opinions of the Attorney General interpreting and clarifying the law hold that the grant should be increased whenever possible up to the limit of one dollar per day.

From time to time the State Pension Department has been asked whether or not the old age assistance grant might be continued when a recipient is confined in a hospital. On January 11, 1937, the State Pension Board adopted a policy of permitting the continuance of old age assistance to a recipient temporarily confined in a private hospital, the Milwaukee County Infirmary or the Wisconsin General Hospital on the grounds that this constitutes temporary medical care and not institutional care. This policy was clarified recently by the adoption of a further regulation on September 12, 1939, which reads: "Old age assistance may continue to be paid to a recipient temporarily confined to any publicly owned or operated hospital or infirmary; provided that, no part of the recipient's grant shall be utilized to reimburse the institution for the cost of hospital, medical or dental care provided by such institution to needy persons, and further provided, that the recipient has continuing extra-institutional expenses such as rent, fuel, clothing and incidentals during the period of his stay in the institution. A recipient's grant should be readjusted to meet such continuing expenses." Payments for medical care in private institutions is subject to the same tests as payment for maintenance care in private institutions.

On July 14, 1937, a regulation was adopted by the State Pension Board defining temporary hospitalization of old age assistance recipients. This regulation provides: "Care in a hospital or institution other than a county home for a period of less than one month would in every case be deemed temporary care; that the specific facts in each case be given great weight but that as a general guiding principle a period of hospitalization for three months or less may in any instance be regarded as temporary."

In conclusion it seems fairly clear that it was the definite intention of the Legislature of the State of Wisconsin to provide medical care and attention for old age assistance recipients, first, through their old age assistance grant,

and second, through the regular relief channels in the event that at the time he requires medical care and attention the old age assistance recipient is receiving the maximum amount of old age assistance allowed under the law.

Special Medical  
Funds for Old  
Age Assistance

Some county boards have followed the practice of setting up special medical funds out of which the county pension department may make payments directly to doctors and hospitals for medical care rendered to old age assistance recipients. Recently the Attorney General considered the question of whether such payments are to be considered as relief or old age assistance payments. In an unofficial opinion dated August 16, 1939, addressed to the District Attorney of Jefferson County, the Attorney General said: "In response to your request of July 24 as supplemented in your letter of July 31; we are of the opinion that payments made for the hospitalization and medical care of those receiving old-age assistance under the circumstances outlined, are not recoverable under the provisions of Ch. 83, Laws of 1939. That law refers only to reimbursement for payment of old-age assistance proper."

This opinion indicates that if the county board of any county sets up a special medical fund to be utilized by the county pension department in paying for medical care and attention for old age assistance recipients, such fund shall be considered as a relief fund rather than as an old age assistance fund. Therefore, reimbursement for payments made out of such fund directly to a doctor or hospital may not be expected from the State or Federal Government.

Medical Societies

Chapter 148 of the Wisconsin Statutes provides for the organization and sets forth the powers of the state medical society and county medical societies. This chapter reads as follows:

"148.01 State society. (1) The state medical society of Wisconsin is continued with the general powers of a corporation. It may from time to time adopt, alter and enforce constitution, by-laws and regulations for admission and expulsion of members, election of officers, and management.

(2) A member expelled from a county medical society may appeal to the state society, whose decision shall be final.

(3) The state society, or a county society in manner approved by the state society, may undertake and coordinate all sickness care of indigents and low income groups, through contracts with public officials, and with physicians and others, and by the use of contributions, co-operative funds and other means, provided only that free choice of physician within such contracts shall be retained and that responsibility of physician to patient and all other contract and tort relationships with patient shall remain as though the dealings were direct between physician and patient. (1935 c. 350)

148.02 County societies. (1) The physicians and surgeons, not less than five in number, of the several counties, except those wherein a county medical society exists may meet at such time and place at the county seat as a majority agree upon and organize a county medical society, and when so organized it shall be a body corporate by the name of the medical society of such county, shall have the general powers of a corporation, and may take by purchase or gift and hold real and personal property. County medical societies now existing are continued with the powers and privileges conferred by this chapter.

(2) Physicians and surgeons who, before April 20, 1897, received a diploma from an incorporated medical college or society of any of the United States or territories or of any foreign country, or who shall have received a license from the state board of medical examiners, shall be entitled to meet for organization or become members of the county medical society.

(3) If there be not a sufficient number of physicians and surgeons in any county to form a medical society they may associate with those of adjoining counties, and the physicians and surgeons of not more than fifteen adjoining counties may organize a medical society under this chapter, meeting at such time and place as a majority agree upon.

(4) A county medical society may from time to time adopt, alter and enforce constitution, by-laws and regulations for the admission and expulsion of members, election of officers, and management, not inconsistent with the constitution, by-laws and regulations of the state society.

The medical societies in the State of Wisconsin by subsection (3) of this statute are given authority to enter into contracts with public officials to coordinate medical care of indigents and low-income groups. On the basis of

this authority and the general powers of the county board found in Section 59.07 (6) and (19) of the Wisconsin Statutes, county boards have entered into contracts with the medical societies of the state specifying certain fee schedules to be utilized in treating individuals dependent upon the public for aid.

## CHAPTER II

### PLANS IN OPERATION

Factors to be  
Considered in De-  
veloping a County  
Medical Program

Before studying the several plans in operation in Wisconsin it may be helpful to set forth objectives and desirable features of a balanced medical program which would encourage harmonious relationships between the agency, doctor and patient.

They are:

1. Mechanics of referral and authorization. There should be a definite plan for authorization which avoids the necessity of contacting more than one agency.
2. Extent of professional participation by individual physicians in giving care to individuals. To many the free choice of physician is important so that the doctor-patient relationship can continue as it was when the patient was self-sustaining. Deviation from the free choice arrangement sets up an interference with normal patient-doctor relationships which may handicap recovery. Further, it is important to realize that many clients have had extensive medical service during their lives and that there is a distinct health advantage in having their needs filled by the physicians who have previously cared for them and to whom their previous history, together with records and examinations, are already known and needs no duplication. A basic principle in the program of social security aids is that a recipient may not be required to spend his grant in any particular way nor to buy commodities or services from any particular person. It is definitely intended that he shall be allowed to choose his own physician whenever payment from the grant is planned.
3. Financial planning to assure maximum federal and state participation.

4. Equitable distribution to participating physician of monies available for medical care. There should be provision for reasonable compensation for care and service rendered.
5. Professional representation in the administration of a medical care program.
  - a. Professional consultation service and practice to implement the most economical treatment in chronic cases and avoid over treatment whenever possible.
  - b. Administrative control of financial matters and administrative policies, the latter preferably to be developed jointly by the medical profession and the county administration.
  - c. Assurance of reasonable standards of quality and quantity of medical care. Reduced rates should never imply inferior quality of treatment or materials.

Explanation of  
Chart I and  
Table II

As explained hereafter there are five general medical plans in operation in Wisconsin Counties.

Chart I entitled, "Plans for Providing Medical Care to Beneficiaries of Social Security Aids in Wisconsin Counties--1939," shows the majority of counties as operating under the joint controlled plan. Further scrutiny will reveal that many counties operate by combining two or more plans.

Table II entitled, "Wisconsin Social Security Medical Aid Costs by Counties, Calendar Year 1938," uses the unduplicated case loads as the basis for arriving at costs per case. It is desirable to point out that the "medical cost per case" figures do not necessarily give a picture of the adequacy of medical care in a county. These figures include only the supplementary payrolls and the special funds appropriated to the pension agencies plus an estimate of the amounts included in the grants. Since some counties prefer to transfer larger medical costs to the relief agency instead of increasing the grants their costs

CHART I

MEDICAL CARE PLANS IN SOCIAL SECURITY AIDS, WISCONSIN, 1939

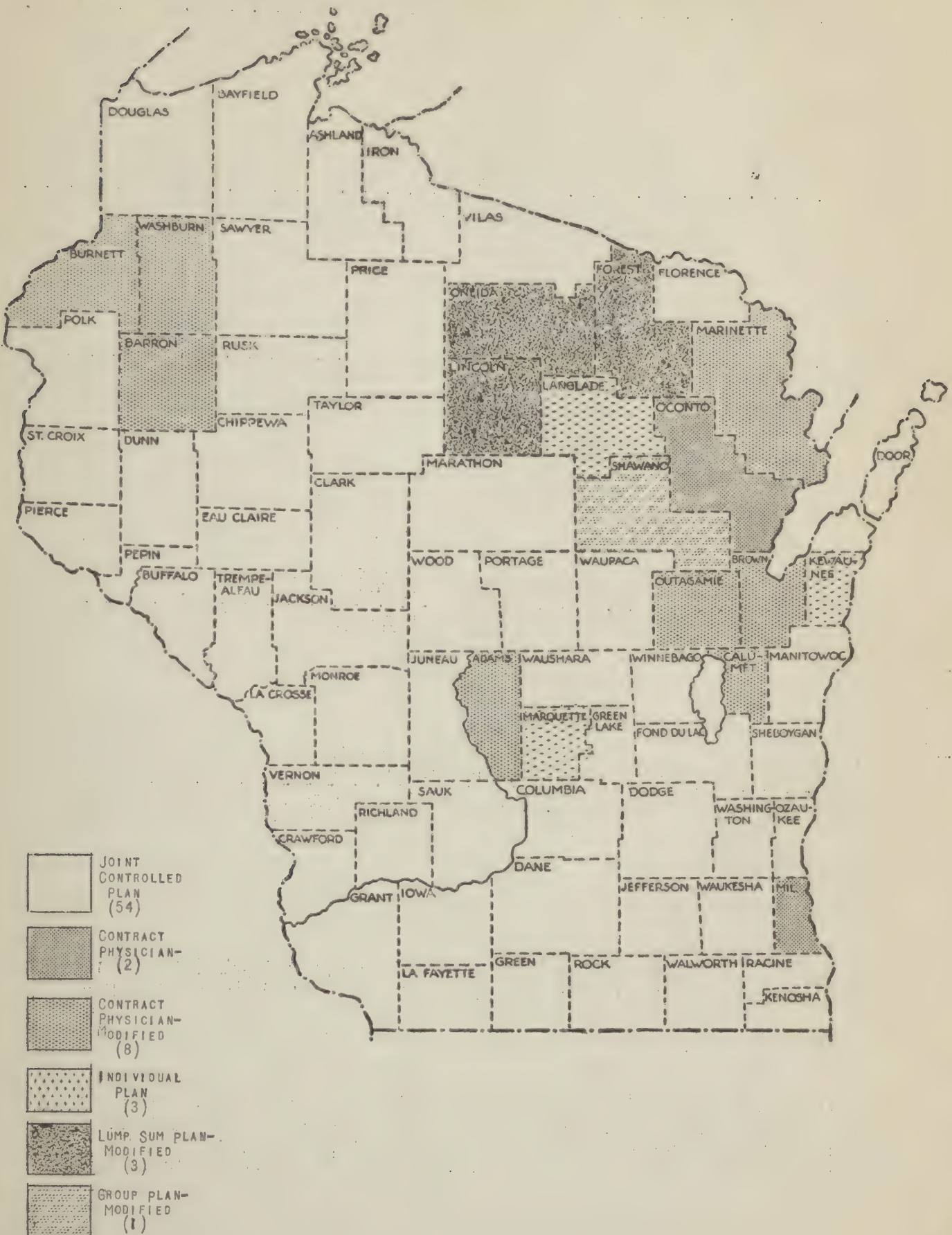


TABLE I  
SOCIAL SECURITY AID MEDICAL COSTS  
(CALENDAR YEAR OF 1938)

County	Total SS/1 Caseload	Total SS/2 Costs	SS Medical/3-4 & Hospital Costs	% of Medical to Total	Medical Cost Per Case	Wisconsin Gen- eral Hospital
Adams	274	\$ 62,819	\$ 1,882	3.0	\$ 6.87	\$ 4,612.50
Ashland	629	180,451	4,114	2.3	6.54	2,907.33
Barron	764	195,721	6,503	3.3	8.51	7,520.10
Bayfield	604	174,022	5,472	3.1	9.06	3,689.70
Brown	798	244,310	11,108	4.5	13.91	8,521.80
Buffalo	299	82,390	4,173	5.1	13.95	1,451.10
Burnett	471	145,970	9,398	6.4	19.95	7,775.71
Calumet	168	43,084	670	1.6	3.98	2,433.90
Chippewa	564	134,087	10,487	7.8	18.59	4,918.00
Clark	499	118,495	14,244	12.0	28.54	9,359.00
Columbia	660	167,809	5,995	3.6	9.08	8,155.50
Crawford	500	114,429	5,000	4.4	10.00	6,050.10
Dane	2048	682,795	43,500	6.4	21.24	
Dodge	869	247,630	22,602	9.1	26.00	8,620.25
Door	272	73,417	4,508	6.1	16.57	4,962.92
Douglas	1171	383,363	40,534	10.6	34.61	1,767.40
Dunn	461	114,784	4,017	3.5	8.71	1,497.30
Eau Claire	994	325,836	10,477	3.2	10.54	1,266.00
Florence	125	35,962	1,200	3.3	9.60	4,074.40
Fond du Lac	1186	434,728	41,473	9.5	34.96	6,274.00
Forest	310	89,015	4,083	4.6	13.17	4,867.80
Grant	914	215,758	11,000	5.1	12.03	12,619.23
Green	362	111,147	5,720	5.1	15.80	8,792.70
Green Lake	156	36,523	1,341	3.7	8.59	4,494.00
Iowa	407	105,734	1,575	1.5	3.87	3,002.40
Iron	153	42,072	1,909	4.5	12.48	1,990.80
Jackson	417	119,502	4,151	3.5	9.95	3,725.40
Jefferson	510	147,170	8,533	5.8	16.83	18,467.40
Juneau	523	120,051	2,383	2.0	4.56	2,291.85
Kenosha	1112	420,013	25,899	6.1	23.28	6,749.10
Kewaunee	127	29,643				785.40
La Crosse	1157	378,435	10,319	2.7	8.92	7,842.00
Lafayette	449	130,509	3,211	2.5	7.15	6,075.00
Langlade	536	159,713	9,209	5.8	17.18	9,879.70
Lincoln	427	102,937	3,800	3.7	8.89	3,236.22
Manitowoc	629	187,178	4,425	2.4	7.03	4,206.30

Marathon	934	\$249,957	\$ 6,460	2.6	6.97	\$ 9,241.50
Marquette	560	146,973	7,495	5.1	13.38	8,066.43
Marquette	195	44,559	1,800	4.0	9.23	3,546.20
Milwaukee	7890	3,077,589	8,641		1.09	
Monroe	476	108,440	4,723	4.4	3.92	4,021.00
Oconto	493	142,678	9,156	6.4	18.57	6,106.01
Oneida	594	170,196	8,400	4.9	14.14	3,995.20
Outagamie	963	280,805	11,684	4.2	12.13	10,208.10
Ozaukee	137	47,416	750	1.6	5.47	2,786.25
Pepin	185	51,336	3,822	7.4	20.06	
Pierce	617	175,705	3,336	1.9	5.50	4,510.80
Polk	609	143,804	4,373	3.5	8.17	5,016.00
Portage	573	137,243	8,112	5.9	14.16	18,889.93
Price	417	91,240	3,786	4.1	8.36	8,786.34
Racine	1274	474,481	21,789	4.6	17.10	11,837.70
Richland	440	98,667	2,172	2.2	4.94	3,487.50
Rock	1170	366,311	18,364	5.0	15.70	17,683.60
Rusk	389	82,572	2,746	3.3	7.06	3,323.70
St. Croix	443	96,914	5,134	5.3	11.59	5,556.60
Sauk	694	164,076	2,234	1.4	3.22	5,346.20
Sawyer	365	98,665	6,708	6.8	18.33	3,303.30
Shawano	611	161,036	13,576	8.4	22.22	2,234.28
Sheboygan	846	272,351	7,791	2.9	9.21	2,593.30
Taylor	364	93,352	6,774	7.3	13.61	5,587.71
Trempealeau	503	124,752	2,677	2.1	5.32	1,361.50
Vernon	606	159,249	11,763	7.4	13.41	4,857.80
Vilas	202	48,534	4,000	8.2	19.80	5,814.30
Walworth	675	175,364	2,415	1.4	3.52	11,098.00
Washburn	503	139,987	8,711	6.2	17.32	5,559.10
Washington	279	78,070	239	.3	.85	2,455.55
Waukesha	638	254,316	7,301	2.9	10.61	224.38
Waupaca	774	216,137	20,462	9.5	26.44	8,206.00
Waushara	397	103,934	6,000	5.7	15.11	8,293.90
Winnebago	1220	380,559	15,393	4.0	12.61	5,531.40
Wood	665	183,284	13,682	7.3		16,905.67

- /1 Unduplicate households, December 1938.  
 /2 Including medical and hospital except Wisconsin General.  
 /3 Estimated amounts included in grants plus supplementary payroll and special funds.  
 /4 Salaries of contract physicians are not included in above totals.  
 /5 Wisconsin General Costs are for the fiscal year of 1937-1938.

as shown here will be materially less. Costs at the Wisconsin State General Hospital are likewise not included in the cost per case figures.

Limitation on Use  
of Appropriations

Preliminary to a study of the plans in operation it must be noted that a county cannot use funds appropriated for old age assistance or blind pension to make payments directly to physicians or for the consideration in contracts with physicians or medical societies. Under existing state statutes payments may be made from aid to dependent children appropriations directly to doctors but there is no federal participation in such payments. However, it is extremely doubtful if such monies could be used for payment on a contract with doctors or a medical society. Characteristic advantages and disadvantages are suggested after the discussion of each of the five plans now in operation. Space does not permit the inclusion of some additional advantages and disadvantages of a debatable nature.

Joint Con-  
trolled Plan

Joint controlled plan, often called fee basis plan, usually involves a signed agreement between participating physicians and the public assistance agency. Conditions of the agreement specify what fees shall be charged for each type of care, sets forth methods of handling various types of medical cases, and establishes methods of authorization, audit and payment. This agreement is arrived at through a conference between the public assistance agency and a committee of the county medical society. Usually each physician decides individually whether he desires to sign the agreement and accept cases at the agreed upon fees. Under this plan a beneficiary in need of medical care obtains from the county administrator an authorization to any one participating physician of his own choice who provides the treatment, and submits a bill either upon the patient's recovery or at a specified time. This bill, along with all others,

is audited by a committee of the medical society for cost and treatment and is allowed according to the fee schedule. Payment is made either through an increase in the grant or by a check directly to the physician.

In sixty-six counties there is an arrangement for paying the physicians treating social security cases according to a fee schedule. In fifty-four of these counties this joint controlled plan operates exclusively; in twelve counties the joint controlled plan operates in conjunction with one of the other four plans explained below and shown on Chart I. In all but four counties the rates have been formally approved by the county medical society.

#### Advantages

1. Establishes definite agreement between profession and public assistance agency as to fees, treatments, audits, policies and procedures.
2. Maintains doctor-patient relationship because free choice is inherent.
3. Allows all doctors to share in benefits provided through public funds for medical care.
4. Permits state and federal participation.
5. Permits professional control.

#### Disadvantages

1. When funds are limited, it may appear that the county director who must authorize before treatment is given is setting the standard of care and determining what services may be rendered. In analyzing the situation in any county, it is necessary to attempt to ascertain whether the county director merely notifies the medical profession that the person under treatment is on the rolls, and therefore, reimbursement can be expected, or whether he advises the physician that treatment may or may not be given according to the diagnosis. One

very successful approach to this problem invokes the active assistance of a rotating medical advisory committee which can make a professional determination of limits for the director's guidance in authorizing treatment, and which can give study to any special cases or difficulties that may arise. The committee membership should rotate in order to avoid a possible charge of discrimination as well as for educational purposes. Counties having rotating, active medical advisory committees usually report a more successful and more economical program.

2. It is difficult to guarantee payment to the doctors unless outdoor relief under-writes or unless a special fund or supplementary payroll is employed.

Contract Physi-  
cian Plan

Another plan in use is one in which there are contracts between cities and physicians as well as between counties and physicians, usually on a competitive bid basis, to provide all medical care for the public assistance recipients. The physician or physicians selected are given a contract for a specified length of time and receive a monthly salary. These contracts embody variable provision as to amount of salary, types of service, amount of service and whether or not the physician may maintain a private practice. Usually he is furnished with a list of people receiving some form of public aid who are eligible for treatment under the contract. This eliminates the need for individual authorizations.

Salaries paid contract physicians range from \$600 to \$3000 per year. Costs of hospitalization are not included. In most instances, the contract specifies that the physicians' services shall include necessary and ordinary

surgery. In one<sup>1</sup> county social security cases are covered by the doctor's contract only after the patients are hospitalized. In one<sup>2</sup> county the contract physicians are required to treat the social security cases without additional reimbursement only if the maximum grant is not large enough to pay for the service rendered. In two<sup>3</sup> instances, the county physicians take over the social security cases only if the person requires a maximum grant for other needs.

A still different arrangement<sup>4</sup> exists in one county whereby the county physicians take over the social security case only if the person resides within a five mile radius of the county seat. This limitation is of practical necessity because of the number of cases within the area. Beneficiaries outside this area are treated under the joint controlled plan.

In two counties<sup>5</sup> where the contracts do not include social security cases beneficiaries are treated on the fee basis plan.

Milwaukee County's plan provides county physicians for all cases. Beneficiaries of the social security aids in Milwaukee County are given medical and dental care through the services offered by the Milwaukee County Dispensary and the Milwaukee County Hospital. Individuals in need of medical care who can leave their homes are permitted to use the facilities of the dispensary. Examination, treatment and drugs are given at this source. The dispensary has a staff of specialists whose services are available to indigents. After submitting proper identification, the person is cleared with the social service exchange, and if it is learned that he is a recipient of one of the social security aids, he immediately becomes eligible for the services of the Milwaukee County Dispensary Staff. When hospitalization is required the beneficiary is sent to the Milwaukee County Hospital.

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<sup>1</sup>Washburn    <sup>2</sup>Burnett    <sup>3</sup>Marinette    <sup>4</sup>Outagamie    <sup>5</sup>Manitowoc, Sheboygan

If he is confined to his home, he can secure adequate medical attention by calling the Milwaukee County Dispensary and asking for one of the doctors on the staff.

Physicians are employed by eight cities of the State to treat public assistance cases. These cities are located in six counties and in only four of the cities are social security cases covered by the contracts. In one<sup>6</sup> county having two cities on this plan, the contract includes social security cases whenever the patients select the contract physician as first choice. In another city<sup>7</sup> only old age assistance and relief cases are included in the contract. Here all medical aid cases, except surgery for social security cases are provided for by a contract with two physicians who each receive \$25 per month.

#### Advantages

1. Under the contract physician plan a city or county can definitely budget the cost of physicians' services for the ensuing year.
2. The necessity of authorizations and audit of bills is eliminated.
3. The departments using a combination of contract physician and joint controlled plan may utilize the services of the contract physician as a consultant and advisor in difficult cases coming under the joint controlled plan.

#### Disadvantages

1. Free choice of physician is not generally recognized nor possible.
2. Treatment is often limited to acute rather than chronic or preventable ailments; avoidance of present cost may result in augmented expense for treatment at a future date.
3. Specialists' services are not always utilized, especially in the

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<sup>6</sup>Green Bay and De Pere, Brown County

<sup>7</sup>Brillion, Calumet County

field of surgery where the contract physician is required to perform all general operative work.

4. No federal or state participation is secured.
5. Transportation problems arise which are eliminated when the local doctor can be used.

#### Individual Plan

This plan has no definite limits. Each individual case is handled as a distinct problem. A different arrangement as to charges, method of payment and type of service in each case is possible under this plan. In general, medical costs are higher in counties operating under this plan, because of the variance in standards, charges, and service. General dissatisfaction with this plan and a tendency toward arbitrary disallowances was reported both by medical society members and county administrators.

#### Advantages

1. Personal contact in each case; therefore the agency is fully aware of all details in every case.
2. Possibility of more favorable prices from some of the doctors.
3. Doctor-patient relationship maintained.

#### Disadvantages

1. Involves considerable inefficiency because of time spent on individual bargaining. Arrangements tend to be verbal rather than written and may eventuate in misunderstandings as well as difficulties in auditing.
2. All physicians are not treated alike, that is, those demanding higher fees profit at the expense of those willing to give a discount.
3. Control of overtreating decreases because there is little if any control by local medical society.

4. There are no uniform standards of treatment because there is no agreement covering standards of care, services rendered and type of hospitalization.

Lump Sum  
Plan

This plan is authorized under section 148.01 (3) Wisconsin Statutes. It permits a county or political subdivision thereof to enter into a contract with the county medical society to provide certain medical services to indigents in need of such services for a specified sum of money. The administration and distribution of this fund is usually left in the hands of the medical society and is usually prorated so that partial payment on the contract is made to the society on a monthly basis. The agency authorizes treatment on standard forms and in the same manner as under the jointly controlled plan. The basic difference between the two plans is the method of raising and dividing the funds among the physicians.

The participating physicians use a fee schedule to determine compensation due individual physicians for services rendered. It appears that the medical costs will be considerably less under this arrangement. However, further experience is desirable before drawing final conclusions as to adequacy of treatment and compensation.

Advantages

1. There is less opportunity for misunderstandings between public assistance agencies and the medical profession.
2. The medical society exercises disciplinary influence over its own membership, and also has control over extent of treatment.
3. The plan offers low cost. One county spent \$7000 under this plan as compared with \$15,000 and \$18,000 in previous years.

Disadvantages

1. There is a danger of making the consideration for the contract so

small that participating physicians do not receive adequate compensation for services rendered, which in turn may lead to the giving of adequate care only to emergency cases. Although this is possible under most plans it is more evident under this plan.

2. Does not allow non-members of medical society to participate.
3. No federal-state contribution.

Group  
Plan

In one northern county an insurance plan was started in January, 1939. This plan provides a means of paying bills of beneficiaries who die before receiving checks or before completing medical installment payments.

A cooperative association was formed by recipients of old age assistance and aid to the blind. They elected the county pension advisory committee of the county board together with two of their own membership to be directors who disburse the funds of the association. Membership fees are 25 cents per year. Premiums must not exceed \$10 per year, or \$1 per month. However, if a grant is already \$30, a beneficiary may pay his 25 cents and participate in the same way as one who has his grant increased to pay the premiums.

The association has devised a fee schedule similar to that in many other counties. Medical, dental, hospital and drugs, special appliances, board bills, etc. are paid by the association according to the approved schedules. However, when the grant is less than \$30, it is increased to the maximum if the \$10 credit has been exhausted, and the beneficiary pays whatever part of his monthly medical bill this increase permits. The unpaid balance at time of death is paid by the association.

The beneficiary deposits the premium in a local bank to the credit of the association. A duplicate deposit slip is issued to the beneficiary, which acts as a receipt to show the secretary of the association that the

premium has been paid. At the present time about 75 percent of all blind pension and old age assistance beneficiaries in this county are members.

#### Advantages

1. The client has free choice of physician.
2. Reasonable assurance of payment is guaranteed not only for medical bills but for other bills incurred prior to death.
3. Membership card serves as authorization.
4. The limited experience of this county indicates that the beneficiaries take an active interest in eliminating unnecessary medical attention. This may be due to the fact that the organization is owned and operated by the beneficiaries.
5. There is indirect federal-state participation in nearly all phases of the medical program.

#### Disadvantages

1. Experience is not yet sufficient to assure that dues will provide enough funds to carry on.
2. Danger of unfairness on part of either or both patients and profession, thus depleting fund.
3. Little if any agency control of expenditures.
4. Voluntary membership results in necessity for another plan to cover non-members.
5. Legality of this plan has not been officially determined.
6. Lack of professional participation.

# CHAPTER III

## AUTHORIZATION AND PAYMENT

This chapter contains an analysis of the methods of authorizing and meeting the payments for medical care. Although most counties extend medical care to all persons in need of assistance, some limit treatment to emergency care. This limitation, however, is in direct conflict with statutory provisions.

### METHOD OF AUTHORIZATION

	<u>Number of Counties</u>
<u>Method of Authorization - Physician and Hospital</u>	
Standard form for medical - - - - -	45
Letter for medical - - - - -	25
Telephone as well as other - - - - -	50
Standard form for hospital - - - - -	43
Letter for hospital - - - - -	23
Telephone as well as other - - - - -	46

	<u>Number of Counties</u>
<u>Dental</u>	
Standard form - - - - -	43
Letter - - - - -	23
Telephone as well as other - - - - -	41

	<u>Number of Counties</u>
<u>Care Authorized Before Given</u>	
Agency must be contacted prior to	
call on doctor - - - - -	41
To entrance to hospital - - - - -	45
To call on dentist - - - - -	46
Doctors' claims recognized	
without prior authorization - - - - -	52
Doctors' claims not recognized	
without prior authorization - - - - -	17
Dentists' claims not recognized	
without prior authorization - - - - -	21

Authorization on Chronic cases Several counties have a policy of requiring frequent re-investigations on chronic cases to serve as a verification of past medical needs in the case, and to keep apprised of the health conditions so as to determine whether an allowance for medical care needs to be continued. Some counties limit costs in chronic cases to a definite amount ranging from \$10 to \$30 per month.

Number of Counties

<u>Consultation</u>	Consultation required on questionable	
<u>Required</u>	diagnosis - - - - -	61
	By a committee - - - - -	18
	By one doctor - - - - -	43
	Wisconsin General - - - - -	57

Use of Consulta-  
tion and Reports  
on Cases

Consultations are required in cases involving surgery, questionable diagnosis or prognosis, long periods of hospitalization or very costly treatments in many counties. A committee of doctors for such consultations is used in some of these counties, while others use only one other doctor. Facilities of the Wisconsin General Hospital are used in a majority of the counties to obtain additional information and treatment on cases involving questionable diagnosis. This service is utilized when either the beneficiary, the doctor or the department believes it to be to the advantage of all concerned to have independent diagnosis, prognosis or treatment.

Number of Counties

<u>Doctors' Reports</u>	Diagnosis required routinely - - - - -	43
<u>Required</u>	Diagnosis required selectively - - - - -	19
	Prognosis required routinely - - - - -	26
	Prognosis required selectively - - - - -	32
	Report on treatment response routinely - - - - -	16
	Report on treatment response selectively - - - - -	31

Reports from doctors - including prognosis and diagnosis - are becoming increasingly useful tools of the agency in providing continuing service and supervision of the health problems.

Number of Counties

<u>Relief Authoriza-</u>	Relief authorization obtained - - - - -	56
<u>tion</u>	Relief authorization obtained by	
	County department - - - - -	23
	Beneficiary - - - - -	2
	Doctor, hospital, dentist - - - - -	17
	Blanket agreement - - - - -	14

An authorization from relief officials to cover medical, hospital or dental bills in case of the death of the beneficiary is obtained in a majority of counties. Responsibility for obtaining this authorization on each case is assumed by the county department in some counties, by the beneficiary in only two counties, by the person or institution rendering service in other counties; however, in 14 counties a working agreement covering all cases has been evolved by relief and social security aid authorities. Under the township system of relief these agreements are usually obtained through conferences between the various town chairmen, the pension board or advisory committee and the pension administrators. Under the county system of relief a conference between the county board relief committee, the pension board or advisory committee and the pension administrator results in a working agreement for this method of underwriting medical, hospital and dental obligations. In those counties having combined departments, such arrangements are merely accounting procedures.

#### METHOD OF PAYMENT

<u>Method</u>	<u>Number of Counties</u>
Relief pays - - - - -	4
Special fund - - - - -	11
Supplementary payroll DCA - - - - -	55
Increasing grant OAA and BP	
For a definite bill - - - - -	47
On an estimate - - - - -	20
Increasing grant DCA	
For a definite bill - - - - -	48
On an estimate - - - - -	19
Receipts required OAA and BP	
For all increases - - - - -	14
For a definite bill - - - - -	31
Selectively - - - - -	15
Receipts required DCA	
For all increases - - - - -	16
For a definite bill - - - - -	22
Selectively - - - - -	20

In the following paragraphs there is a discussion of each item in the above table.

Relief . . . , Relief pays all medical costs for old age assistance and blind pension cases in some counties of the state. Although from an administrative standpoint this may be the easier method there is no federal participation and very little, if any, state participation in costs of medical aid given social security aid beneficiaries under this method of payment. In view of the opinion of the attorney general there is some question as to propriety of this practice as far as old age assistance is concerned.<sup>1</sup>

Budgetary Allowance . . . An unverified budgetary allowance of \$1 to \$2 has been made in the old age assistance and blind pension grants in some counties. Five counties make such an allowance in every old age assistance and blind pension case, and the others in from 1 to 20 per cent of such cases. This practice was generally followed early in the program; however, counties report that such an allowance has proved to be wasteful because when a real medical need arises rarely, if ever, has any of this money been saved for the emergency.

Special Fund . . . A supplementary payroll, drawing on a county board appropriation<sup>2</sup> made expressly for social security medical cases, is used to care for medical costs for old age assistance and blind pension cases in some counties; two of these pay for all medical needs in this manner. All hospital costs are paid by such a fund in one county, four use this method only when the federal maximum is exceeded, one uses its fund when experience indicates that the beneficiary is not using the medical allowance in his grant

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<sup>1</sup> See Chapter 1. Pages 7, 8, 9, 10.

<sup>2</sup> See Chapter 1. Page 10.

to pay medical costs. The special fund is used in three counties when the federal maximum is exceeded in aid to dependent children, or when the beneficiary does not properly expend the increase made in old age assistance and blind pensions. (See opinion of attorney general - chapter 1 - which reviews the legality of such funds.)

Supplementary  
Payroll

A supplementary payroll which allows the counties to receive state reimbursement is used to pay for medical services rendered recipients of aid to dependent children in 39 counties. Thirty-four counties use this method in all cases. The other five use a supplementary payroll only when the federal maximum is exceeded.

It is apparent that the use of the supplementary payroll is a more efficient procedure from an administrative standpoint because bills are paid directly instead of through the beneficiary, but its value is somewhat questionable when consideration is given to the fact that there is no federal participation, and with the exception of aid to dependent children cases, no state participation.

Increases  
in Grant

An increase in old age assistance and blind pension grants for medical or dental aid only when a definite bill is presented as verification of the need is made in some counties; others increase grants for medical aid upon a statement from the physician or dentist as to the estimated cost of the service to be rendered. An increase for medical or dental care in aid to dependent children grants is made in some counties only when a definite bill is presented as verification, others increase aid to dependent children grants upon a statement from a physician or dentist showing an estimate of the cost of the service to be rendered. The practice of making an increase on the basis of estimated costs is believed to be wasteful, unless adjustment to verified costs is made. The counties which increased old age assistance and

blind pension grants without a doctor's statement limited such increases to an amount varying from \$1 to \$5.

Receipts

Receipts for increases made in old age assistance and blind pension grants for medical purposes are required in 60 counties, 14 of these require receipts for all medical increases, 31 only when the increase is for a definite sum, 15 require receipts on a selective basis.

Receipts are occasionally required for increases made in aid to dependent children grants in 58 counties. Sixteen of the 58 require receipts for all increases for medical purposes, 22 when the increase is for a definite bill and 20 on a selective basis.

CHAPTER IV

SPECIAL PHASES

Seven counties in the state do not have hospitals within their boundaries and must rely upon hospitalization in neighboring counties, or the Wisconsin State General Hospital. However, there are only two small areas in the state where people are over 30 miles from a hospital.<sup>1</sup>

No corresponding variety of plans exists for hospital care as does for medical treatment. Four<sup>2</sup> counties operate their own hospitals which care for social security as well as relief cases. One county has a group system already explained under medical plans. Of the remaining counties 49 have schedules of reduced rates. The other 17 bargain for rates or accept prices asked. County poor farms, asylums and sanitoriums are not included in this survey.

County  
Hospital

The counties operating county hospitals or infirmaries use them generally for the chronic and non-technical cases;

other cases go to the other hospitals. However, in one large county, the facilities at the county hospital appear to be adequate to care for any type case.

Advantages

1. It is possible to operate a ward for the chronic or convalescing patients at a lower rate than hospitals regularly charge.
2. The necessity of audit and individual payment is eliminated.

Disadvantages

1. Client is denied free choice of hospital.
2. Other hospitals cannot share in the amount spent for hospital care.
3. There may be a tendency to attempt treatment of difficult cases for which the hospital is not equipped.
4. There is a lack of state and federal financial participation.

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<sup>1</sup> The State Medical Society of Wisconsin. Special Committee to study the Distribution of Health Service and Sickness care in Wisconsin. 1938 Page 18.  
<sup>2</sup> Lincoln, Marathon, Milwaukee, Walworth.

Private  
Hospitals

In fifty-two counties beneficiaries are permitted to choose any hospital within the county while 48 of the 52 allow the choice to extend to neighboring counties. For distribution of hospitals see Table II on the following page. However, when such out-of-county choices are made, 23 counties insist that the rates shall not exceed those of the local hospitals. Only 3 counties in the state report that reduced rates are not extended when the beneficiary pays the bill out of his increased grant. The reluctance on the part of these hospitals to give a reduced rate under these conditions can probably be eliminated if the counties will assume the responsibility of securing authorization from the relief department to cover expenses in the event of the death of the client before payment is completed. Hospital authorities feel that under existing circumstances their financial risk is so great in this type of case that their giving reduced rates is unwise, whereas a guarantee of the costs would justify them to give reduced rates.

Number of Counties

Dental Plans

School Dentists - - - - -	16
Dental Clinic - - - - -	1
Joint Controlled (or Fee Schedule) Plan -	40
No Definite Plan - - - - -	30

Extent of  
Care

Possibly the dental program has not been as fully developed in most counties as the medical program. It is usual to provide care, such as extractions and immediately urgent treatments. Preservative and preventative care has been neglected partly because of the expense and partly because of the fact that the results of neglect are not immediately manifest. Need for development in this field appears to be indicated both from the standpoint of general health and of economy.

TABLE II  
DISTRIBUTION OF PHYSICIANS AND HOSPITALS

County	Population 1930 Census	No. of Physicians	Population <sup>1</sup> per Physician	No. of Hospitals	Hospital Beds	Population <sup>1</sup> per Hospital	Population per Hospital Bed
Adams	8003	3	2668	1	12	8003	667
Ashland	21054	19	1108	2	150	10525	140
Barron	34301	25	1372	4	105	8575	327
Bayfield	15006	7	2144	1	20	15006	750
Brown	70249	73	962	3	400	24163	176
Buffalo	15330	9	1703	1	12	15330	1277
Burnett	10223	6	1704	1	25	10223	408
Calumet	16848	11	1532	0	0	-	-
Chippewa	37342	30	1245	2	204	18671	183
Clark	34165	21	1527	2	20	17082	1708
Columbia	30503	33	924	3	103	10167	296
Crawford	16781	16	1049	2	80	8390	210
Dane	112737	271	416	8	1221	14092	92
Dodge	52092	35	1488	3	110	17364	474
Door	18182	9	2020	2	30	9091	606
Douglas	46583	36	1294	3	226	15528	206
Dunn	27037	14	1931	1	25	27037	1081
Eau Claire	41087	40	1027	2	345	20544	200
Florence	3768	0	-	0	0	-	-
Fond du Lac	59883	62	965	2	290	24992	206
Forest	11118	6	1853	1	25	11118	445
Grant	38469	30	1282	7	153	5436	251
Green	21870	19	1151	1	35	21870	625
Green Lake	13913	14	9931	1	25	13913	557
Iowa	20039	14	1431	2	40	10020	501
Iron	9933	5	1980	0	0	-	-
Jackson	16468	9	1830	1	28	16468	588
Jefferson	36785	36	1022	2	87	18393	423
Juneau	17264	14	1233	1	30	17264	575
Kenosha	63277	55	1150	2	210	31639	301
Kewaunee	16037	11	1458	3	35	5339	458
La Crosse	54455	50	1089	4	520	13614	105
Lafayette	18649	17	1097	2	18	9325	1036

<sup>1</sup> The ratio which shows population per physician and population per hospital may be somewhat misleading since the clientele of physicians and hospitals are not limited by county boundaries

County	Population 1930 Census	No. of Physicians	Population per Physician	No. of Hospitals	Hospital Beds	Population per Hospital	Population per Hospital Bed
Langlade	21544	14	1539	2	45	10772	479
Lincoln	21072	13	1621	3	120	7024	176
Manitowoc	58674	141	416	2	158	29337	371
Marathon	70629	38	1859	3	300	23543	235
Marinette	33530	23	1458	1	50	33530	671
Marquette	9388	9	1043	1	10	9388	939
Milwaukee	725263	888	816	16	2497	45329	290
Monroe	28739	21	1369	1	75	28739	383
Oconto	26386	14	1885	2	52	13193	507
Oneida	15899	12	1325	1	60	15899	265
Outagamie	62790	55	1142	1	200	62790	314
Czaukeee	17394	12	1450	0	0	-	-
Pepin	7450	5	1490	1	20	7450	373
Pierce	21043	15	1403	3	99	7014	213
Polk	26567	20	1328	5	60	5313	443
Portage	33827	28	1228	1	90	33827	376
Price	17284	0	-	0	-	-	-
Racine	90217	77	1172	6	431	15034	209
Richland	19677	17	1157	1	70	19677	281
Rock	72206	74	975	4	280	18052	258
Rusk	16081	8	2010	1	35	16081	459
St. Croix	25455	21	1212	1	21	25455	1212
Sauk	32030	33	970	3	100	10677	320
Sawyer	8878	6	1480	0	0	-	-
Shawano	33516	17	1972	2	65	16758	516
Sheboygan	71235	65	1096	3	310	23745	230
Taylor	17685	7	2526	1	35	17685	505
Trempealeau	23910	23	1040	3	60	7970	399
Vernon	28537	22	1297	2	40	14269	713
Vilas	7294	5	1459	0	0	-	-
Walworth	31058	44	705	2	62	15529	501
Washington	11103	-	-	0	0	-	-
Waukesha	26551	23	1544	3	81	8850	328
Waupaca	52358	65	806	2	80	25179	654
Waushara	33209	30	1107	5	100	6642	332
Winnebago	14427	7	2061	0	0	-	-
Wood	76622	70	1095	2	450	38311	170
	37862	34	1114	2	200	18933	189

The range in fees for similar services as between dentists in some counties seems unreasonable.<sup>1</sup> The practice of sending beneficiaries around to several dentists for appraisals and awarding the business to the one who bids lowest does not conform with modern standards of public assistance administration or with the codes of practice of dental societies.

Although dental bills are regularly audited by members of the dental society in sixteen counties, more counties might benefit from a rotating dental advisory committee.

	<u>Number of Counties</u>
<u>Public Health</u>	
<u>Resources</u>	
County nurse <sup>2</sup> - - - - -	62
City school nurse	
Full time - - - - -	53
Part time - - - - -	1
Rural school nurse - - - - -	20
Wisconsin Anti-Tuberculosis Assn. Clinic -	64
Venereal Clinic - - - - -	12
Dental Clinic - - - - -	32
Diabetic Clinic - - - - -	1
School Dentists - - - - -	16
Special appropriation for Social Security	
Medical Aid - - - - -	11

Programs sponsored by the nurses include public health classes, home nursing classes, classes on infant care, tuberculosis testing, immunization programs and clinics of various types.

Cooperating                      Sixty-two counties report active Red Cross Chapters, 42  
Community  
Organizations                American Legion Posts, 33 Kiwanis Clubs, 27 Lions, 11 Eagles,  
                                  27 Elks, 13 Moose, 36 Masonic, 38 church, 38 Women's Clubs,  
 18 private agencies, and 35 other organizations are also extending worthwhile support. These numbers do not purport to be a complete count of the entire group of service clubs active in this phase of the program. However, they do

<sup>1</sup> See Table V Page 47

<sup>2</sup> As reported by the county pension departments.

indicate the number reported by the county administrators.

The programs sponsored by these organizations include: Dental, medical, and hospital aid, special appliances, glasses, white canes for the blind, cod liver oil, educational programs, clinics, recreation supervision and equipment, summer camps for under-privileged children, special diets, milk for school children, school lunches, and free beds in hospitals and sanatoria.

Some organizations limit these services to members only. The majority have no such limit and in many instances try to provide for border-line cases and those who are not receiving public aid. Public assistance programs attempt to encourage the activities of this nature on the part of local service clubs, and the policy of assisting border-line cases is commendable. It is recommended that these organizations clear with local welfare offices before going into a case too far in order to avoid duplication of effort and funds.

#### Optical

	<u>Number of Counties</u>
Glasses to all - - - - -	59
Glasses to school children only - - - -	6
Total - - - - -	65
Recommended by:	
Physician only - - - - -	23
Physician or Optometrist - - - - -	42

#### Home Nursing

	<u>Number of Counties</u>
Practical-Cost from \$2.50 to \$10 a week -	53
Registered-Cost from \$3.50 to \$7 a day -	25

Practical nursing service is provided in many counties; some counties provide registered nurses when recommended by a physician. In many cases nursing service decreases the expense of treatment by eliminating the cost of hospitalization as well as promoting rapid recovery of patient.

#### Drugs

	<u>Number of Counties</u>
By some physicians - - - - -	53
By pharmacists - - - - -	63
Discounts - - - - -	24
Range from 10 to 50%	

In most counties there are some physicians who dispense their own drugs. Drugs are purchased from pharmacists in practically all counties.

	<u>Number of Counties</u>
<u>Special</u>	Recognized by - - - - - 68
<u>Diets</u>	On physicians' statements only - - - 63
	On nurses' statement only - - - 3
	On clients' statement only - - - 2

Special diets are recognized in most counties, in a majority on physician's statement only, in only three on a nurse's statement and in two on the client's statement. In 54 counties these diets are checked from time to time as to results and whether they are being followed. Some counties have endeavored to work out substitute diets which are less expensive than those originally prescribed. This is done with the assistance of the physician on an individual case basis.

	<u>Number of Counties</u>
<u>Sight</u>	Restorative treatment
<u>Conservation</u>	Allowed for in grant - - - - - 29
	Special fund - - - - - 6
	Local private charity - - - - - 1
	Relief funds - - - - - 14
	Wisconsin General - - - - - 45
	Grant suspended if treatment refused - - - 13

An allowance for restorative treatments is made in the grant in some counties, some have a special fund, one depends on local private charity, several on relief funds, a great many occasionally use facilities of the Wisconsin State General Hospital or local hospitals with authorization by the county court under Chapter 142, Wis. Stats. A policy of suspending the grant if restorative treatment is refused is reported by a few counties. This policy is felt to be too stringent because the group receiving blind pension is composed chiefly of aged persons. It is suggested that whenever there is reasonable doubt that an operation will be successful it should not be required,

During the calendar year 1838, 56 blind pension cases received restorative treatment and 46 received some preservative treatment. This represents about 5.1 per cent of the entire blind load. At first glance this number seems low, but it must be remembered that approximately 50 per cent of those receiving blind aid are over sixty-five and 28 per cent are between fifty and sixty-four years of age.

	<u>Number of Counties</u>
<u>Examination of</u>	
<u>Incapacitated</u>	
<u>Fathers</u>	
Free choice by patient - - - - -	55
Second examination by county selected physician - - - - -	38
Use of Local Clinics - - - - -	16
Use of Special Committee - - - - -	13
Fee range \$1 to \$5	
Treatment	
From relief - - - - -	66
Other sources - - - - -	5

Free choice of physician in examinations to determine degree of incapacitation is allowed in a majority of counties. Some send the father to a second physician. In several counties local clinics are utilized to obtain these reports while a few counties use a special committee to pass on these examinations, particularly when the diagnosis and prognosis are somewhat difficult or questionable. Wisconsin State General Hospital facilities are occasionally utilized by 32 counties to secure special diagnosis and by 50 counties for treatment requiring special skills and equipment.

Fees for examinations of incapacitated fathers range from \$1 to \$5, the usual fee being \$2. These fees are paid as administrative expense in most counties. Fees are paid from relief funds in some counties, and a few report that families bear this expense.

Rehabilitative  
Treatment of  
Incapacitated  
Father

Treatment intended to promote physical rehabilitation of incapacitated fathers is obtained through relief officials in 66 counties. The others provide this treatment through other channels, such as Wisconsin General Hospital and local private charity. Two counties discontinue aid to dependent children if relief refuses to provide recommended rehabilitative treatment. Under a recent opinion of the Attorney General it is possible to provide treatment from Social Security funds.<sup>1</sup>

Several county administrators reported difficulty in getting authorization for treatment of incapacitated fathers from relief officials, particularly in those counties on a township system of relief. Through rehabilitative treatment 89 cases were closed in the last calendar year because the father has sufficiently recovered from his incapacitation to take his normal place in the family.

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<sup>1</sup> See Page 5.



## CHAPTER V

### EVALUATIONS AND CONCLUSIONS

This chapter deals with evaluations and recommendations of county administrators and officers of county Medical Societies. It also contains conclusions on suggested methods of authorization, payment and general operation of a medical program.

#### EVALUATION AND RECOMMENDATIONS BY COUNTY ADMINISTRATIONS AND COUNTY MEDICAL SOCIETIES

##### County Department Problems

Difficulties with doctors overtreating and overcharging occurred in 13 counties according to the administrators' statements. Lack of cooperation on the part of the local medical society was reported by the same 13 administrators. A lack of control of treatments and care was reported by five administrators. A general need for specialists who would be available for consultations and special treatment was reported. Difficulties because beneficiaries do not properly expend increases granted for medical aid were reported by seven counties. In many instances improper use of increases could probably be eliminated by more thorough casework.

One or two counties registered other problems which were caused mainly by lack of funds, absence of agreements between the medical society and department, and difficulties in division of responsibility between pension departments and relief officials.

It appears that most difficulties are due to a lack of mutual understanding and cooperation between the hospitals, medical and dental societies and the county departments. A program of mutual education would tend to eliminate many misunderstandings.

Quantity of  
Treatment

The quantity of medical care received by beneficiaries of social security aids is greater than the average taxpayer purchases, according to the opinion of 55 county administrators. The quality and quantity is the same as that obtained by the average taxpayer in the opinion of 14 county administrators. Treatment is inferior to that purchased by the average taxpayer in the opinion of two county administrators.

Recommendations  
of County Ad-  
ministrators

It would be advisable to allow use of a supplementary payroll for old age assistance, according to recommendations made by 17 counties. Two of these specified that it should be used only when an increase in the grant can not cover the cost of medical treatment.

Sixteen counties feel that a uniform fee schedule and plan would be advisable either on a state-wide or regional basis. Four requested help in sponsoring a program of education for staff members, and members of local medical societies. Four asked that specialists be provided by the state agency for purposes of consultation. Other suggestions include uniform authorization forms, more active medical society committees, reimbursement on treatment of incapacitated fathers, staff physicians and more state services on medical aid.

Conscientious planning and cooperation by interested parties can make some of the suggestions a reality. A series of conferences between medical society members and administrators and staff members would do a great deal toward promoting mutual understanding and cooperation.

County Medical  
Society Recom-  
mendations

Practically all society officers indicated a desire for payments direct from the county department, rather than increasing grants to beneficiaries. A large per

cent of those interviewed felt that closer cooperation between societies and departments would be very beneficial to the whole program. The few definite complaints against the pension department's medical program concerned those beneficiaries who do not pay their bills. A surprisingly large proportion of the doctors interviewed (about 65 per cent) indicated a desire for an educational program for both society members and county departments to promote an understanding of the law and a solution of mutual problems.

### CONCLUSIONS

The ideal plan should have the simplest referral, reports, authorization and other necessary procedures possible, so that a beneficiary may receive the best possible medical care at the lowest cost with a minimum of red-tape and time.

To accomplish this it is recommended that each county department in cooperation with the local medical society study conditions in the locality and work out a plan which best meets the particular needs of that locality.

In studying this problem it is well to bear in mind the following factors which have an important bearing on the problem of medical care: Location of the potential medical load and the physicians who will serve them. Is mileage a big factor in costs of care? Is travel in the winter more difficult than in the summer? Location of hospitals, clinics, and other facilities which are sometimes essential. Experience with other medical plans, prevailing fees in the county for public assistance cases. How do they compare with surrounding counties? (See Tables IV, V, VI) Too low a fee schedule promotes ill feeling and results in lack of cooperation and inefficiency just as too high a fee schedule is also uneconomical.

TABLE III

## MEDICAL FEES AND NUMBER OF WISCONSIN COUNTIES PAYING EACH -- 1939

	\$5.00	7.51	11.00	13.51	16.00	20.00	26.00	31.00	41.00	51.00	66.00	76.00
	7.50	10.00	12.50	15.00	19.00	25.00	30.00	40.00	50.00	65.00	75.00	over
<u>SURGERY</u>												
Major												
Appendectomy					1	4	3	15	30	2	3	
Cataracts								8	19	3		1
Call Bladder						4	1	12	24	4	7	1
Prostate						2		8	20	4	7	
Minor												
Tonsils (Hosp)		12	13	26	7	4						
Tonsils (Off)		7	6	24	7	2						
*Confinement												
Hosp.	1	12	6	25	6	4						
*Confinement												
Home		2	6	36	6	7	1					
<u>FRACTURES &amp; DISLOCATIONS</u>												
Fractured												
Arm	1	3	3	11	3	14	4	6				
Fractured												
Femur	1		2	3	1	13	3	7	4			
Dislocated												
Shoulder	2	6	17	6	4	9	1	1	1			
Dislocated												
Hip	1	2		3	2	24	3	6	2			

\*Fees include prenatal and postnatal calls in 55 counties.

## MILEAGE FEES ALLOWED DOCTORS AND NUMBER OF COUNTIES PAYING EACH

Mileage										Summer	Winter			
One Way	.05	.06	.07	.10	.13	.20	.25	.30	.50	.12	.25	.25	.40	.50
Number of														
Counties	1	1	3	1	1	1	27	1	7	7	6	7	1	5

TABLE IV

HOSPITAL FEES AND NUMBER OF WISCONSIN COUNTIES PAYING EACH -- 1939

	50¢	75¢	\$1.00	\$1.50	\$1.75	\$2.00	\$2.25	\$2.50	\$3.00	\$3.50	\$3.75	\$4.00	\$5.00	\$5- \$10	\$10- \$15
Day Call			9	45			1								
Night Call			3	10		25	2	16	5		1				
Hospital Call	6	2	23	14	1										
Office Call	19	5	37	1											
Private Room			2	2	1	12		13	7	5	4	4	1		
Double Room			1	2	2	11	2	15	5	1	2				
Ward			1	3	4	21		22	2						
Operating Room								3					14	30	5

FEES CHARGED BY HOSPITALS WHICH INCLUDE ROOM, OPERATING  
ROOM AND ALL HOSPITAL CARE.Per DayCounties

\$2.38  
3.25  
2.40  
2.50  
1.00  
1.00

Jackson  
Crowford  
Richland  
Vernon  
Rhinelander (City)  
Oneida

TABLE V

DENTAL FEES AND THE NUMBER OF WISCONSIN COUNTIES PAYING EACH 1939

		.50	.75	1.00	1.25	1.50	1.75	2.00	2.25	2.50	2.75	3.00	3.50	4.00	4.50	5.00	7.50	8.00	10.00	13.50	15.00	17.50	20.00	22.50	25.00	30.00	35.00	40.00	45.00	50.00
Extractions	4	1	48																											
Maximum			3															1	37	1	2									
Pulp Cap	4	2	37			1																								
Cement Filling	1	5		1	40																									
One Surface																														
Amalgam	1	1	43	2	1																									
Two Surface																														
Amalgam	1				2	2	41																							
Three Surface																														
Amalgam	1						1	3	3	1	36				1															
Silicious Cement	1		2	1	1	1	1	38				1																		
Post & Pre-Oper-																														
ative Treatments	2		39		1			1																						
X-Ray (Single)	2		39		1			2		1																				
X-Ray (Full)*			1																											
Dental Surgery					1																									
Prophylaxis			4		1	1	1	26		1		1																		
Pyorrhea	1		4	36									1	1		1														
Single Denture																														
Full Dentures																														

\*In thirty counties full x-rays specifies minimum of twelve exposures

Authorization

The simplest procedure for authorizing care is ordinarily the most satisfactory. At the same time it is necessary that certain complicating elements must be included in an authorization. Due to the fact that it is usually impossible to make payments direct to the doctors and others rendering medical aid in old age assistance and blind aid cases, out of regular appropriations, it is necessary to so word the approval for treatment form that it informs the person or institution to whom authorization is given that the beneficiary will be responsible for the payment of any bills incurred and that the agency's financial responsibility ends when it makes an increase in the grant to cover the amount of the bills incurred.

Some counties have successfully arranged a plan whereby the relief officials automatically underwrite all such authorizations to the extent that when death occurs before bills are paid the unpaid portion thereof is paid from relief funds. This plan is probably the most workable and satisfactory in operation today.

Under one successful method which is sometimes used when the automatic arrangement is not feasible, the pension department contacts the relief official on each case and secures a guarantee of payment from him which is effective whenever the beneficiary cannot pay the bills. This assumption by the pension department of responsibility for a complete authorization through either method is a logical one. It is administratively easier for the agency to contact the relief official and secure an agreement on a definite plan than it is for the doctor or hospital to contact both the relief and pension departments and attempt to effect an agreement between the agencies on each case. Some counties which follow the latter plan have forms which go from the doctor back to the pension department, then to the relief

authority and finally consist of a written authorization from both agencies. The essential defect in this latter plan is the time involved in getting the second authorization. The pending period is, of course, one of uncertainty. One hospital representative stated that reduced rates could be given to cases where the beneficiary paid from his grant, only if the pension department would assume authority for complete authorization.

For counties having a medical plan which requires authorization it is suggested that a client coming to the office be given a simple form of referral to the doctor of his choice. Such a referral form simply asks the doctor to make an examination and give a report. (See Form M-1 attached). The report form which the doctor fills out should provide for diagnosis and prognosis and approximate costs. Upon the receipt of this report form, the county agency is in a position to discuss the case intelligently with the doctor, other interested agencies, and the beneficiary, and to give the doctor a definite authorization to perform specified services. This authorization form should outline the proposed method of payments. The previously mentioned procedures which secure an automatic authorization from the relief authority are recommended as means of simplifying the medical program and securing better rates. Form No. M-4 is designed for use when this arrangement is in effect.

It is advisable to request a report on the examination made by the doctor. This report is necessary, so that the agency can be aware of any recommendations the physician may make as to change in living conditions, diets, necessary hospitalization, etc. It is strongly recommended that the various agencies give consideration to some working arrangement with the various doctors and institutions providing medical services so that this reporting can be accomplished with a minimum of confusion. Perhaps a form similar to No. M-1 attached will simplify procedures. This report form is a part of the referral and could be filled out by the physician to show the nature of

the patient's illness and to indicate whether or not further treatment, special diet, etc., is advisable. If it is prepared in triplicate the doctor can be given two copies, one of which he will return to the agency.

One of the three following forms will usually be appropriate for any type of medical arrangement that may arise. Form 2-M can be used when payment is made from a special medical fund or supplementary payroll.

Form 3-M gives an explanation to the doctor when the grant is increased to include the medical bill.

Form 4-M is designed for the counties which have secured an authorization or guarantee of payment from the relief official.

These suggested forms can be adapted to local situations as necessary.

MEDICAL REFERRAL

\_\_\_\_\_ County

Name \_\_\_\_\_

Pension Administration

Beneficiary

Address \_\_\_\_\_

12

Dr. \_\_\_\_\_

Referred for \_\_\_\_\_

Date \_\_\_\_\_ Referred By \_\_\_\_\_

REPORT OF DOCTOR

Complaint \_\_\_\_\_

Physical findings \_\_\_\_\_

Diagnosis \_\_\_\_\_

Outline of Treatment \_\_\_\_\_

Duration of illness \_\_\_\_\_ Patient should  
be reexamined \_\_\_\_\_

Estimate No. of treatments per month \_\_\_\_\_ Total Approx-  
imate Cost \_\_\_\_\_

Remarks \_\_\_\_\_

Date \_\_\_\_\_ Signature \_\_\_\_\_ M. D.

Notice to Doctors: Payment for this call: ☐ will be included in patient's grant  
☐ has been included in patient's grant  
☐ will be made by this office direct  
to you

Form M-2

FOR COUNTIES WHEN PAYMENT IS FROM SPECIAL MEDICAL FUND

OR SUPPLEMENTARY PAY ROLL

AUTHORIZATION FORM

\_\_\_\_\_ County Name \_\_\_\_\_  
\_\_\_\_\_ Pension Administrator Address \_\_\_\_\_ Beneficiary  
\_\_\_\_\_.19

\_\_\_\_\_ treatment of \_\_\_\_\_  
Hospital, Surgical, or Medical  
\_\_\_\_\_ is hereby authorized, as reported by you  
on Form M-1, the expense thereof to be charged to the Pension Department  
of \_\_\_\_\_.

Signed: \_\_\_\_\_

\_\_\_\_\_  
Official Title

FOR USE BY COUNTIES WHEN PAYMENT IS MADE IN GRANT

APPROVAL FOR MEDICAL TREATMENT FOR SOCIAL SECURITY BENEFICIARY

\_\_\_\_\_  
County Name \_\_\_\_\_  
\_\_\_\_\_  
Pension Administration Address \_\_\_\_\_  
\_\_\_\_\_  
19

To \_\_\_\_\_ You are hereby notified that  
\_\_\_\_\_ is a recipient of  
\_\_\_\_\_ and that this agency will, upon receipt of  
a statement of the cost of services rendered the above recipient, (or  
upon receipt of a statement of estimated expense of services to be ren-  
dered the above named recipient) increase his/her grant of \_\_\_\_\_ so  
that he/she can pay either the entire bill or make partial payments  
thereon; if partial payments are made this increase in grant will con-  
tinue until such time as the entire bill has been paid. This agency  
can assume no responsibility for insuring payment of any bill incurred  
by this beneficiary other than increasing the grant of said beneficiary  
as much as possible to provide the beneficiary with funds with which to  
pay for services rendered.

\_\_\_\_\_  
Director, Co. Pension Department

FOR USE OF COUNTIES WHEN PAYMENT IS UNDERWRITTEN BY RELIEF

AUTHORIZATION\*FOR MEDICAL CARE FOR SOCIAL SECURITY BENEFICIARIES

County \_\_\_\_\_ Name \_\_\_\_\_  
Beneficiary \_\_\_\_\_  
Address \_\_\_\_\_  
Pension \_\_\_\_\_  
Administration \_\_\_\_\_ 19\_\_

To \_\_\_\_\_ You are hereby authorized to provide such medical care for \_\_\_\_\_, a recipient of \_\_\_\_\_ as may be necessary. Such care is to be provided at the rate as set forth in the agreement of fees between this agency and the County Medical Society. \*It is understood that an increase will be provided in the above named recipient's grant to pay for this care and that in the event of the death of this beneficiary before payment is complete the county (or town) relief authorities have agreed to pay that portion of the amount charged which is still unpaid at the time of the beneficiary's death.

Director, County Pension Dept.

Payment  
Methods

From the standpoint of local finances, including a medical allowance in the grant seems to be the most economical. However, there is much to be said for paying out of special appropriations, through relief funds, or by means of contracts with individual physicians or county societies.

Experience indicates that the most logical procedure is a combination of parts of each of the above methods; one of the better procedures studied provides medical aid through the grant when possible and when the beneficiary evidences ability and willingness to expend an increase for medical aid. The fees charged are billed according to an approved schedule and are audited monthly before being allowed in the grant. When a beneficiary dies or does not properly expend medical increases the county pays for services rendered out of a special medical appropriation provided by the county board of supervisors for this purpose.

Still another workable plan provides that the beneficiary has free choice of physician when the individual's budget allows the inclusion of an amount to pay for services rendered; when such an amount can not be included the beneficiary must go to a contract physician who cares for all public assistance charges on a contract basis.

When the budget is to be increased to care for medical needs, it should be increased with such a change dependent directly upon a bill or statement from the hospital or doctor. Sometimes it will be desirable to make an allowance on the basis of an estimate; however, this can later be adjusted when bills or receipts are presented. It is permissible to allow for chronic medical needs without continuously requesting a receipt or statement, but the majority of increases should be based on verified need.

The plan of routinely including \$1 to \$2 in the grant for medical aid is

NEW INFORMATION

The use of receipts as a means of verifying payments by a beneficiary to a hospital or doctor has been suggested on pages 55 and 56 of this report. This procedure has been utilized in some instances when the grant includes an allowance for authorized medical care.

The following is quoted from a letter of October 23, 1939, from the Bureau of Public Assistance of the Social Security Board:

"The requirement that the recipient return a receipt by the creditor is contrary to the policy of restrictive payment."

The foregoing is interpreted as meaning that requiring a receipt showing the use made of a part of an assistance grant is no longer permitted. County pension administrators are advised that continued use of receipts involves risk of loss of federal participation.

In advising you of this development the State Pension Department suggests that the county departments will still find it possible to advise the doctor or hospital whenever the assistance grant includes an allowance for medical care and to request a report of failure on the part of the beneficiary to pay. It is also desirable that the practice of advising a beneficiary when his grant has been adjusted to permit payment of doctor or hospital bill be observed. This will place the recipient on notice of his own responsibility to pay his bill.



not economical and is not recommended. The personal allowance should be large enough to provide for purchase of the usual home remedies and supplies.

Receipts are a useful means of verifying the increases made on the basis of estimates. They are also useful where ledgers are maintained to show unpaid balances on medical bills incurred. But to use them indiscriminately on every increase requires excessive administrative time and may be irksome to many honest and conscientious beneficiaries who will see to it that their bills are paid.

When a grant is increased for a medical bill, both the doctor and client should be so notified. If receipts are not to be required in a case, the doctor can be asked to report any failure to pay.

Patient, Doctor  
Agency Inter-  
pretation

Interpretation by the doctor to the agency or worker is often necessary in order to justify the care needed or granted, and as a means of gaining the understanding cooperation of the worker. Many workers can alter their casework methods to fit the needs of a beneficiary who is ill. The worker has a similar responsibility of interpretation to the doctor so he can be assured that the worker's interest in the diagnosis and prognosis is not one of curiosity, but is rather in terms of how it affects recovery, rehabilitation and cost, and the agencies' ability to meet these demands. Certainly the doctor is more apt to respond if he knows why and from what angles the agency is interested.

Advisory  
Committee

In those counties having active medical advisory committees composed of members of the medical profession, costs are lower, relationships between the profession and the agency are much better and in general the program is improved. These committees not only audit bills but act as advisors to the agency on difficult cases and assist in the formulation of rules and regulations and new policies.

They then interpret these policies, rules and regulations to the members of their profession. The most successful of these committees are composed of a membership that rotates periodically so that eventually each member of the profession serves on the committee and becomes acquainted with the staff and policies of the agency.

The results of this study indicate that every county should give careful consideration to the formation of such a committee, not only from the standpoint of financial economy but because of the many benefits to both the agency and the profession through development of better relationships which in turn assures better care for the people served by the agency and the profession.

In making this study it was observed that in those counties which did not have an advisory committee the members of the medical profession were in general unaware of certain restrictive policies over which the local administrator had no control and were in some instances blaming the administrator for apparent discriminations which in fact were caused by these restrictive policies. Such a situation would be preventable through dissemination of proper and pertinent information via a cooperating advisory medical committee, chosen by the county medical society.











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